80-5303

Supreme Court, U. S.
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IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

No. 80-

ANTONIA BELTRAN
~~ROSSYE DAWSON~~, individually and on behalf of all others similarly situated,

Petitioner,

v.

BEVERLEE A. MYERS, individually and in her official capacity as Director of the California State Department of Health; and ELISABETH LYMAN individually and in her official capacity as Deputy Director of the State Department of Health,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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QUESTIONS PRESENTED

1. Whether the application by California of a "transfer of assets" rule to its medically needy aged, blind, and disabled applicants for, and recipients of, Medicaid, resulting in the denial of assistance to individuals otherwise eligible, contradicts the applicable portions of the Social Security Act and thus violates the Supremacy Clause.

2. Whether the application by California of a "transfer of assets" rule to its medically needy aged, blind, and disabled applicants for, and recipients of, Medicaid, resulting in the denial of assistance to individuals otherwise eligible, violates the due process and equal protection clauses of the Fourteenth Amendment.

LIST OF PARTIES

Petitioner: Antonia Beltran*

Respondents: Beverlee A. Myers and Elisabeth Lyman

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* Rossye Dawson, whose name has remained on the papers throughout this litigation, died while this case was before the district court. Enosinsio Manahan, another named plaintiff, died while the case was before the Court of Appeals. Antonia Beltran is the remaining named plaintiff.

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OPINIONS BELOW

The opinion of the Court of Appeals, as yet unreported, appears as Appendix A. The district court's unreported Findings of Fact and Conclusions of Law of May 10, 1979, with the summary judgment order, are attached as Appendix B.

JURISDICTION

The Court of Appeals filed its Opinion on May 14, 1980. On July 30, 1980, a timely petition for rehearing and rehearing en banc was denied (Appendix C), with this petition for certiorari filed within 90 days of that date. This Court's jurisdiction is invoked under 28 U.S.C. §1254(1).

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CONSTITUTIONAL, STATUTORY AND REGULATORY PROVISIONS INVOLVED

The following provisions are significantly involved in this case, and, because of their length, are cited here, with their pertinent texts set out verbatim in Appendix D:

1. United States Constitution, 14th Amendment, §1 (due process and equal protection clauses)

2. Title 42, United States Code, §§1396a(a)(10)(C); 1396a(a)(17)(B)

3. California Welfare and Institutions Code §14015

4. Title 42, Code of Federal Regulations, §435.401(c)(2)

5. Title 22, California Administrative Code, §§50409, 50411(a)

6. Social Security Administration Claims Manual, §12507(a)

STATEMENT OF THE CASE

1. California participates in the Medical Assistance ("Medicaid") program established by Title XIX of the Social Security Act, 42 U.S.C. §1396, et seq.

> "This cooperative federal-state program is designed to provide medical assistance to certain classes of individuals who are in need of such assistance. Although states are not required to participate, if they choose to do so they must develop a plan which conforms to the federal guidelines. 42 U.S.C. §1396a(b) .... After a state's plan is approved by the Secretary of [the Department of Health and Human Services], the state then receives reimbursement for a portion of the funds which are expended. 42 U.S.C. §1396." Dawson v. Myers, No. 79-3246, Slip Op., at 2 (9th Cir., May 14, 1980) (App. A, at 2).

Under the federal formula, California is reimbursed 50% of its costs. 44 Fed.Reg. 10553 (Feb. 21, 1979).

A necessary condition of participation and reimbursement is that the state comply with controlling federal law. E.g., Fabula v. Buck, 598 F.2d 869, 870-871 (4th Cir. 1979).

In theory, the Secretary of the Department of Health and Humand Services ("HHS") can deprive the state of its matching funds, 42 U.S.C. §1396c, but as that is the sole sanction available to the Secretary, she rarely, if ever, takes that action. Instead, the Secretary undertakes a process of informing and warning the state of its non-compliance, an effort intended to avoid the drastic remedy of terminating payments to the state. 45 C.F.R. §201.6; see generally Rosado v. Wyman, 397 U.S. 397, 405 n.8 (1970).

Within the confines of the federal statute and regulations, the states have considerable latitude in structuring their programs. If a state decides to participate, it must provide assistance to the so-called categorically needy, who are those individuals meeting both the categorical definitions of age, blindness, disability, or childhood dependency, and their financial eligibility conditions. Even so, the state has flexibility in defining the eligibility conditions of the categorically needy. It can either use the same eligibility conditions as are applicable to recipients of Supplemental Security Income ("SSI"), the federally-administered and -funded welfare program of cash assistance to the aged, blind and disabled, Title XVI of the Social Security Act, or it can use more restrictive eligibility conditions, but no more restrictive than those validly in effect in the state on January 1, 1972. Compare 42 U.S.C. §1396a(a)(10)(A) with 42 U.S.C. §1396a(f); see Slip Op., at 2 & nn.1,2; (App. A, at 2, 17 nn.1,2); see also, e.g., West v. Cole, 390 F.Supp. 91, 95-99 & nn.5,6 (N.D.Miss. 1975). California, like most states, has explicitly chosen to provide Medicaid pursuant to the SSI eligibility conditions. Slip Op., at i n.2 (App. A, at 17 n.2). It is informally

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known, therefore, as an "SSI state."

A state also has the option of providing Medicaid to the "medically needy", who also must meet the categorical definitions but whose income or resources are above the categorically needy levels. 42 U.S.C. §1396a(a)(10)(C); see, e.g., Beal v. Doe, 432 U.S. 438, 440 & n.1 (1977); Friedman v. Berger, 547 F.2d 724, 726 (2d Cir. 1976), cert. denied 430 U.S. 984 (1977). "The medically needy begin receiving assistance after they have incurred medical expenses which reduce their income (and assets) below a prescribed level." Slip Op., at 3 (App. A, at p.3.) California does include the medically needy in its state plan. Id., at 3 (App. A, at p.3.)

In its Medicaid program, which it calls "Medi-Cal", California has adopted a transfer of assets rule.

> "Basically, this prevents persons from qualifying as medically needy if they have transferred assets for less than fair consideration within two years prior to their application for assistance. The transfer rule applies to applicants in the medically needy group; it has no application at all to the categorically needy." Slip Op., at 3 (App. A, at p.3) (emphasis in original).

The eligibility conditions deny medically needy assistance to individuals with resources valued over $1500, 22 Cal.Admin.C. §50420, but homes and certain other properties are exempt from consideration. 22 Cal.Admin.C. §50418, 50425-50489. But if an asset, whether or not exempt, is transferred for less than fair consideration prior to application, a presumption arises that the transfer was effected in order to obtain Medi-Cal eligibility.[1/] The individual is then denied eligibility for a period of time which reflects the actual value of the transferred asset, the cost of care, and the value received for the asset. 22 Cal.Admin.C. §50411.

1/ Whether this presumption is rebuttable or irrebuttable is one of the issues of this case. See, infra, at 17-18.

California has been told by HHS that the application of any transfer rule to its medically needy, however it is worded, violates federal law. As early as September 29, 1978, respondent Myers was informed by letter that the state could not apply a transfer rule to its medically needy aged, blind, and disabled. California has not altered its regulations, and HHS has continued with its efforts to force compliance with federal law. Amicus Brief of Secretary of HHS, lodged in support of Appellants' Petition for Rehearing.

2. The sole living class representative in this case, Antonia Beltran, is, like Rossye Dawson and Enosinsio Manahan, who have died during the course of this litigation, an elderly, sick individual who requires convalescent care but who has been found ineligible for Medi-Cal as a result of the transfer of assets rule. She is now 88, and will require nursing home care indefinitely. About a year prior to her entry into the home on March 20, 1978, she and her husband grant-deeded some land with two houses on it, one of which they lived in, to their children because of the parents' inability to care for the property. They had been determined eligible for Medi-Cal since May, 1977, but she was terminated effective September, 1978, for reasons which are unclear. She re-applied, but was denied assistance in a decision dated January 8, 1979 because of the February, 1977 transfer of the property. The county computed her period of ineligibility to be 885 months, just under 74 years. The most recent bills from her nursing home indicate that she is in debt to the home for over $20,000.

As the Court of Appeals observed,

> "[b]oth Beltran and Manahan were medically needy and otherwise qualified to receive Medi-Cal benefits. However, both were denied benefits based on the fact that they had transferred assets for less than adequate consideration prior to applying for Medi-Cal. Neither

was able to overcome the presumption of ineligibility resulting from these transfers." Slip Op., at 4 (App. A, at 4).

3. This case was filed in forma pauperis by Rossye Dawson on June 19, 1978. Enosinsio Manahan and Antonia Beltran later intervened; Rossye Dawson died before the case was decided on the merits. The intervenors' complaint, like that of Rossye Dawson, sought declaratory and injunctive relief on their own behalf, and on behalf of similarly situated Californians seeking medically needy coverage, invalidating and enjoining the state's policy of denying or terminating Medi-Cal benefits to those who had allegedly transferred assets for less than fair consideration.

The district court granted plaintiffs' motion for class certification on May 10, 1979. On the same day, the court denied plaintiffs' motion for summary judgment, and granted defendants'. The court found that the plaintiffs would have been eligible for Medi-Cal but for the application of the transfer of assets rule. (App. B, at 27.) In its conclusions of law, the court recognized that it had jurisdiction under 28 U.S.C. §1343(3), (4), and 28 U.S.C. §1331.[2/] (App. B, at 27.)

2/ The Court of Appeals questioned, but did not resolve, whether jurisdiction was proper pursuant to 28 U.S.C. §1343(3) and (4), citing Chapman v. Houston Welfare Rights Organization, 441 U.S. 600 (1979), and Doe v. Klein, 599 F.2d 338 (9th Cir. 1979). Slip Op., at ii n.6 (App. A, at 18 n.6). Since the amount in controversy exceeded $10,000, however, "the district court did clearly have federal question jurisdiction (28 U.S.C. §1331)." Id., at ii n.6 (App. A, at 18n.6)(citations omitted). The Court of Appeals had jurisdiction over the appeal pursuant to 28 U.S.C. §1291. Id., at ii n.6 (App. A, at 18 n.6).

The district court agreed with plaintiffs' basic contention that California had obligated itself to provide Medi-Cal to all SSI recipients and that "a state may not impose conditions of eligibility on the medically needy that are more restrictive than those imposed on the categorically needy, that is, recipients of SSI." Conclusions of Law, ¶¶8, 10 (App. B, at 30). Despite these conclusions, it held that the application of a transfer of assets rule to the medically needy (but not to the categorically needy) was permissible, as the rule was a "collateral restriction" and was therefore a "procedural regulation" not a "substantive eligibility requirement." Id., at ¶¶10-11 (App. B, at 30).

As a member of the class was, on the very date of the decision (May 10, 1979), about to be evicted from her nursing home because the transfer rule had rendered her ineligible, she sought an injunction pending appeal from the district court. That was denied by that court on May 11 after plaintiffs filed their Notice of Appeal, but upon docketing the appeal on that same date, she sought and obtained a temporary injunction from an appellate judge.[3/] The request for an injunction pending appeal for the one class member was later extended for the duration of the appeal, but denied without prejudice for the class. That request was renewed upon oral argument, but was denied by the panel hearing the case. Another class member, however, later faced with imminent eviction, also received an injunction pending appeal which provided Medi-Cal benefits during the pendency of the appeal.

3/ Because the appeal had to be filed and docketed immediately, there was not sufficient time to obtain and file the necessary affidavits for the appeal to proceed in forma pauperis.

The panel's decision of May 14, 1980 affirmed the district court, but on considerably different grounds. First, the court specifically repudiated the district court's characterization of the transfer rule, and recognized that it was a substantive eligibility requirement. Slip Op., at 7 (App. A, at 7). But the decision then ignored the explicit interpretation of HHS by determining that the "comparability" language in the statute, 42 U.S.C. §1396a(a)(10)(C), did not require that the medically needy be treated equally with the categorically needy. Slip Op., at 8, 11-13 (App. A, at 8, 11-13.)

The court also held that there was no violation of the "availability" requirement of 42 U.S.C. §1396a(a)(17), as it held that a state can consider former resources to be available. Id., at 11 (App. A, at 11). The court rejected in a footnote plaintiffs' arguments that the transfer rule presented an eligibility condition not countenanced by the Social Security Act, id., at iii n.8 (App. A, at 19 n.8), and held that due process was not violated as the transfer rule did not utilize an irrebuttable presumption. Id., at 13-14 (App. A, at 13-14.) Finally, the panel concluded that there was a rational basis to treat the medically needy differently than the categorically needy, and thus disposed of the equal protection claim. Id., at 14-16 (App. A, at 14-16).[4/]

In light of the fact that three other appellate courts, one state and two federal, had recently reached the diametrically opposite conclusion on plaintiffs' first argument, and that HHS had specifically corroborated the propriety of that argument,

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4/ Since the court ruled against plaintiffs, it explicitly refused to consider plaintiffs' request for an order detailing the manner in which relief should be provided. Slip Op., at v n.13 (App. A, at 21 n.13).

plaintiffs sought a rehearing. On July 21, 1980, HHS lodged an amicus brief supporting plaintiffs' request for a rehearing and repudiating the panel's conclusion that HHS had not directly spoken on the issue of this case. See Slip Op., at 8-9 (App. A, at 8-9). On July 30, 1980, the request for a rehearing and for a rehearing en banc was denied. The court also refused to permit the filing of the HHS amicus brief. (App. C, at 33.)

REASONS FOR GRANTING THE WRIT

I. THE COURT'S RULING ON PETITIONER'S FIRST CLAIM DIRECTLY CONTRADICTS THE INTERPRETATION OF THE RESPONSIBLE FEDERAL AGENCY AND THREE APPELLATE COURTS, AND NECESSARILY VIOLATES A LONG-STANDING PREMISE OF MEDICAID LAW UPHELD BY EVERY COURT WHICH HAS CONSIDERED THE ISSUE

Petitioner's first argument to the courts below involves a simple two-step analysis. First, the categorically needy aged, blind, and disabled (i.e., SSI recipients) do not and cannot have a transfer of assets rule applied to them in determining Medicaid eligibility. Regardless of whether they have transferred, and regardless of the value of the property and the value received for it, they cannot be deprived of Medicaid eligibility. This is so because the Social Security Administration specifically forbids consideration of asset transfers in determining SSI eligibility, Social Security Administration Claims Manual, §12507(a) (App. D, at 37), and because, in the SSI states, the SSI eligibility conditions must be applied to categorically needy Medicaid applicants. 42 U.S.C. §1396a(a)(10)(A). See Blum v. Caldwell, 100 S.Ct. 1635, 1637 (1980) (Marshall, J.) (denying request for

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stay)[5]; Caldwell v. Blum, 621 F.2d 491, 494 (2d Cir.1980), pet. for cert. pending No. 79-2034, 49 U.S.L.W. 3005 (June 24, 1980); Fabula v. Buck, supra, 598 F.2d, at 874 n.13; Scarpuzza v. Blum, 426 N.Y.S.2d 505, 508 n.8, 73 A.D.2d 237 (2d Dept. 1980).

Secondly, a state is forbidden from applying more restrictive eligibility conditions to the medically needy than to the categorically needy. The statute and regulations require this equal treatment, so that the only permissible distinction between the categorically and medically needy is that the latter may have more liberal income and resource eligibility conditions applied to them. 42 U.S.C. §1396a(a)(10)(C); 42 C.F.R. §435.401(c).[6]

The panel's conclusion permitting application of a transfer rule is in direct conflict with two other federal appellate courts, both of which determined that the argument outlined above forbade an SSI state from applying a transfer rule to its medically needy. Caldwell v. Blum, supra; Fabula v. Buck, supra. It also directly contradicts a New York state appellate court which relied on the same reasoning. Scarpuzza

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5/ A second application for a stay of Caldwell -- New York's transfer of assets case -- was made after the decision below came down. It was referred to the entire Court and also denied. 100 S.Ct. 2959 (1980).

6/ Case authority for this proposition is cited in full, infra, at p.13 n.9. The only decision with a contrary conclusion, Fabula v. Solomon, 463 F.Supp. 830 (D.Md.1978), was reversed on this point. Fabula v. Buck, supra, 598 F.2d, at 873.

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v. Blum, supra. And, another federal court, also relying on this same argument, declared that Massachusetts' transfer rule violated federal law. Robinson v. Pratt, No. 79-1278-S (D.Mass., June 24, 1980).7/

In addition, the panel's conclusion contradicts the interpretation and order of the responsible federal agency. HHS has informed state Medicaid directors that the relationship between the categorically and medically needy required that the SSI states not apply transfer rules to the medically needy. See Fabula v. Buck, supra, 598 F.2d, at 873 n.10; Caldwell v. Blum, supra, 621 F.2d, 495; Slip Op., at p.8 (App. A, at p.8); Scarpuzza v. Blum, supra, 426 N.Y.S.2d, at 513 & n.19. Indeed, it directly informed defendant Myers of this noncompliance by letter of September 29, 1978. Moreover, HHS has published this interpretation, again based on the arguments made here by petitioners. Health Care Financing Administration Regional Office Manual, Part 6, Medicaid Guidelines, Transmittal No. 31, §1937, reported at CCH Medicare & Medicaid Guide, ¶30,092. And, HHS attempted to file an amicus brief in the Ninth Circuit supporting petitioners' request for a rehearing in which again it noted the propriety of this argument.

In addition to the deviation from this specific interpretation, the decision below also violates the established interpretation of the Medicaid statute which requires states not to apply more restrictive rules to the medically needy than to the categorically needy. HHS details this statutory requirement by regulation: "The [state] agency must not use requirements for determining eligibility for optional coverage

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7/ That court, however, has refused to enjoin application of the state rule on the grounds that it is solely the obligation of HHS to force a state to comply with federal law.

groups that are -- ... (2) For aged, blind, and disabled individuals, more restrictive than those used under SSI ...." 42 C.F.R. §435.401(c).[8/] In the comments to other regulations, which were also dependent on this policy, the agency explained:

> "[42 U.S.C. §1396a(a)(10)(C)(i)] means that while a state might use more generous maintenance amounts in determining financial eligibility ..., all other SSI eligibility criteria are to be used .... [A]ll aged, blind, and disabled persons applying in states covering all SSI eligibles must have their eligibility determined using all SSI eligibility rules except for -- and only except for -- higher dollar amounts for income and resource eligibility levels." 42 Fed.Reg. 2684 (Jan. 13, 1977).

HHS, though, has not been alone in this interpretation. The courts have unanimously agreed that eligibility conditions can be no more restrictive for the medically needy

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8/ This regulatory requirement was previously codified at 42 C.F.R. §448.2(b)(2) and 45 C.F.R. §248.2(b)(2). See Caldwell v. Blum, supra, 621 F.2d, at 497 n.8.

than for the categorically needy.[9/] Indeed, if there is one interpretation of the federal Medicaid statute on which everyone was in agreement, it was this. The Ninth Circuit's decision explicitly deviates from this established authority by interpreting the statute to permit more restrictive treatment of the medically needy.

Thus, with respect to the propriety of transfer of assets rules in the SSI states, the decision of the court below directly contrasts with the decisions of two other Courts of Appeals and with a state appellate court. It also specifically

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9/ Caldwell v. Blum, supra, 621 F.2d, at 497-498, aff'g CCH Medicare & Medicaid Guide, ¶30,093 (N.D.N.Y.1979); Fabula v. Buck, supra, 598 F.2d, at 873; Greklek v. Toia, 565 F.2d 1259, 1261 (2d Cir. 1977), cert. denied sub nom. Blum v. Toomey, 436 U.S. 962 (1978); Friedman v. Berger, supra, 547 F.2d, at 729; Winter v. Quern, CCH Medicare & Medicaid Guide, ¶30,572, at 10,343 (N.D.Ill.1980), previous opinion in same case on same point (by different judge) sub nom. Winter v. Trainor, CCH Medicare & Medicaid Guide, ¶28,151, at 10,599 (N.D.Ill.1977); Hendrickson v. Noot, CCH Medicare & Medicaid Guide, ¶30,499, at 9920 (D.Minn.1980); Dawson v. Beach, supra, Conclusions of Law ¶10 (App. B, at 30); Aitchison v. Berger, 404 F.Supp. 1137, 1149 (S.D.N.Y.1975), aff'd without opinion 538 F.2d 307 (2d Cir.), cert. denied 429 U.S. 890 (1976); Dominguez v. Milliken, CCH Medicare & Medicaid Guide, ¶26,633 at 9221 (W.D.Mich.1973); Schaak v. Schmidt, 344 F.Supp. 99, 103-104 (E.D.Wis.1971) (3-judge court); Scarpuzza v. Blum, supra, 426 N.Y.S.2d, at 511-512; Wong v. Brian, CCH Medicare & Medicaid Guide ¶26,605, at 9014-9015 (Cal.Ct.App.1972). See also Blum v. Caldwell, supra, 100 S.Ct., at 1637.

repudiates the explicit interpretation of the responsible federal agency, despite the deference which is normally paid to agency interpretation and despite the court's inability to demonstrate that that interpretation is inconsistent with the statute.[10/] In addition, the court below contradicts the numerous other courts, and HHS, which have considered the larger issue of proper treatment of the medically needy.

In rejecting New York's first application for a stay, Justice Marshall observed: "The terms of the Social Security Act support the judgment of the Court of Appeals [for the Second Circuit], and the agency responsible for administering the Act is in complete accord with the decision below." Blum v. Caldwell, supra, 100 S.Ct., at 1638. Given that context, the contrary decision of the Ninth Circuit should be reviewed by this Court.

II. THE DECISION BELOW ALSO DEVIATES FROM THOSE OF COURTS EVALUATING PETITIONER'S OTHER SUPREMACY CLAUSE CONTENTIONS

1. Petitioner also argued that application of the transfer rule has the effect of assuming resources available which are not, in fact, available, in violation of 42 U.S.C. §1396a(a)(17)(B). The court rejected that contention as "an overly rigid and literal interpretation of the term 'available' ...." Slip Op., at 11 (App. A, at 11).

There are, however, numerous cases which have strictly interpreted the availability requirement in subparagraph (B) to mean actual availability, as opposed to

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10/ See, e.g., Udall v. Tallman, 380 U.S. 1, 16 (1965); Caldwell v. Blum, supra, 621 F.2d, at 497; Fabula v. Buck, supra, 598 F.2d, at 873.

presumed availability. See, e.g., Brown v. Stanton, 617 F.2d 1224, 1227-1231 (7th Cir.1980), pet. for cert. pending No. 79-1690, 48 U.S.L.W. 3734 (April 24, 1980); Manfredi v. Maher, 435 F.Supp. 1106 (D.Conn.1977) (noting, in the context of Medicaid "deeming", that Congress intended that states not count income which was not in fact available). And, this Court, in its evaluation of the similar availability rule in the Aid to Families with Dependent Children ("AFDC") program, has repeatedly emphasized that states may not merely presume availability. Van Lare v. Hurley, 421 U.S. 338 (1975); Lewis v. Martin, 397 U.S. 552 (1970); King v. Smith, 392 U.S. 309 (1968).

Moreover, courts have also interpreted the availability requirement to forbid the application of transfer of assets rules: "[B]y denying eligibility for assistance over a period of time during which a transferred asset would otherwise sustain the applicant, were it still available, the rule assumes the availability of unavailable resources, in clear contradiction of the case law doctrine." Buckner v. Maher, 424 F.Supp. 366, 373 (D.Conn.1976), aff'd sum. 434 U.S. 898 (1977); see also Udina v. Walsh, 440 F.Supp. 1151, 1155 (E.D. Mo.1977). Contra, Lerner v. Division of Family Services, 235 N.W.2d 478 (Wis.1975); Rinefierd v. Blum, 412 N.Y.S.2d 526, 66 A.D.2d 351 (4th Dept. 1979).[11/]

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11/ Neither the Rinefierd nor the Lerner court had the issue presented in petitioner's first argument, discussed, supra, at 9-14, before it. The court's reliance below on those cases (Slip Op., at 16 (App. A, at 16)), is thus inappropriate in evaluating that issue. See Fabula v. Buck, supra, 598 F.2d at 873 n.10; Scarpuzza v. Blum, supra, 426 N.Y.S.2d, at 510-511.

2. In addition, the use of a transfer rule violates the requirement that states not employ eligibility conditions which are not countenanced by the Social Security Act and which deprive otherwise eligible individuals of benefits. The court below rejected this argument in a footnote. Slip Op., at iii n.8 (App. A, at 19).

This requirement, though, has been conclusively established and adhered to by this Court:

> "[I]n the absence of congressional authorization for the exclusion clearly evidenced from the Social Security Act or its legislative history, a state eligibility standard that excludes persons eligible for assistance under federal AFDC standards violates the Social Security Act and is therefore invalid under the Supremacy Clause." Townsend v. Swank, 404 U.S. 282, 286 (1971); see also Carleson v. Remillard, 406 U.S. 598 (1972); King v. Smith, supra.

This analysis has been expressly utilized in evaluating transfers of assets rules: "Nowhere in the Social Security Act or in the HEW regulations is there intimation that the mere transfer of assets within two years prior to or during the recept of assistance is to operate as a lever which thrusts the burden of explanation therefor on the applicant." Owens v. Roberts, 377 F.Supp. 45, 55 (M.D.Fla.1974) (3-judge court); see also Fabula v. Buck, supra, 598 F.2d, at 874; Buckner v. v. Maher, supra, 424 F.Supp., at 373; Udina v. Walsh, supra, 440 F.Supp., at 1156.

The states cannot accept federal funds while depriving individuals of benefits by using eligibility conditions which the Act expressly forbids or for which it makes no provision. The decision below on these points violates explicit judicial authority.

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III. THE NINTH CIRCUIT'S DECISION ALSO CONFLICTS WITH DECISIONS ENFORCING CONSTITUTIONAL GUARANTEES

1. Petitioner also argued that California's transfer rule is an irrebuttable presumption which denies her due process. The court determined, however, that the presumption was rebuttable and that there was no constitutional infirmity in discounting evidence that the transfers were not effected in order to obtain eligibility. Slip Op., at 14 (App. A, at 14).

This Court and others have repeatedly determined that irrebuttable presumptions violate the due process clause of the Fourteenth Amendment. E.g., Vlandis v. Kline, 412 U.S. 441 (1973); U.S. Dept. of Agriculture v. Murry, 413 U.S. 508 (1973); Owens v. Roberts, supra. In that latter case, in which Florida's transfer rule was invalidated, the three-judge court noted that the state "regulation ... arbitrarily and irrationally forecloses from eligibility for welfare assistance those individuals who have transferred an asset worth more than $600.00 for less than its assessed or fair market value without regard whatsoever for the good faith of the individual claimant." 377 F.Supp., at 51. In this instance, though more subtly accomplished, the state is taking the same action.

The California statute irrebuttably presumes that a transfer for less than adequate consideration was effected "with intent to qualify for assistance and such act shall disqualify the owner for further aid ...." Welf. & Inst. Code §14015. The regulation implementing that statute, while nominally rendering the presumption rebuttable, permits the applicant only to use "objective facts", and precludes introducing evidence of "subjective intent", i.e., that the

applicant had other, non-fraudulent reasons for transferring. Moreover, the regulation specifically renders irrelevant two explanations which often represent the reason in fact for the transfer: that the individual sought to avoid probate costs or problems (a common action by elderly people) or that the individual was unaware that Medi-Cal existed. 22 Cal.Admin.C. §50409(b)(2). In short, the presumption is only superficially rebuttable; since the state will not consider the most common innocent reasons which an applicant might have, it effectively renders the presumption irrebuttable.

The California rule effectively prevents most applicants from demonstrating the reasons for their actions, thereby establishing a conclusive presumption. By validating that rule, the court below has created a conflict with the numerous courts which have rejected irrebuttable presumptions.

2. Finally, the Ninth Circuit refused to find the differential treatment of the medically and categorically needy to be an equal protection violation. The court found a rational basis for this distinction in the financial savings to the state. Slip Op., at 15 (App. A, at 15). In that conclusion, however, the court ignored the several decisions, including those of this Court, which have refused to view fiscal concerns as providing a sufficient rationale for discriminatory treatment. See, e.g., Memorial Hospital v. Maricopa County, 415 U.S. 250, 263 (1974); Medora v. Colautti, 602 F.2d 1149, 1153 n.9 (3d Cir. 1979); Silbowitz v. Secretary of H.E.W., 397 F. Supp. 862, 867 (S.D.Fla.1975) aff'd mem. 430 U.S. 924 (1977).

Moreover, the court below also determined that the medically needy and categorically needy were not identically situated, Slip Op., at 15 (App. A, at 15), on the theory that the former had more income and resources than the latter. But

that reasoning ignores the Congressional conclusion that those not receiving cash benefits (i.e., the medically needy) are equally impoverished when their incomes are reduced by medical costs. Indeed, the very premise of the medically needy program was to recognize the equality of poverty which existed between the two groups when medical costs were taken into consideration. See, e.g., Aitchison v. Berger, supra, 404 F.Supp. at 1149 & n.43; Brown v. Beal, 404 F.Supp. 770, 778-779 (E.D. Pa.1975).[12/] Once a state opts to provide for the medically needy, it has accepted equality of treatment between the two groups - except, as HHS recognizes, that the medically needy may have more liberal eligibility rules applied to them. See 42 Fed.Reg. 2684 (Jan. 13, 1977).

The impropriety of differential treatment of the two groups has been repeatedly noted by other courts in the statutory context. Supra, at 13 n.9. It has also been suggested that this discrimination may rise to a constitutional violation. See, e.g., Aitchison v. Berger, supra, 404 F.Supp., at 1149. And the Fourth Circuit has noted, in the same context as this case, that there is no rationale for punishing one group of Medicaid applicants for behavior which does not subject

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12/ The court's confusion on this point is especially glaring in light of its misunderstanding of how Title XIX is structured. In explaining how Congress distinguished between the two groups, the court notes: "It must be remembered that the categorically needy receive benefits regardless of whether a state adopts a medicaid program under Title XIX." Slip Op., at 15 (App. A, 15). That is wrong; there is no such requirement. Participation in the federal Medicaid program is entirely optional. The court has failed to grasp the basics of Title XIX.

the other group of Medicaid applicants to any sanction: "[W]e question how the transfers made by plaintiffs, which would be expressly permitted under SSI guidelines, can be fraudulent acts under the Medicaid program simply because they are performed by the medically needy rather than by an SSI recipient." Fabula v. Buck, supra, 598 F.2d, at 874 (footnote omitted).

If there is any logic in denying medical assistance to individuals who transfer assets for less than valid consideration, that logic is equally applicable to the categorically needy. The rule is therefore both underinclusive and overinclusive; there is no valid explanation for differential treatment of these similarly situated Medicaid applicants.

CONCLUSION

The decision below expressly contradicts numerous decisions of this and other federal and state courts. Support for petitioner's position is overwhelming, and on one argument, petitioner's first, is unanimous. In this circumstance, it is entirely appropriate that a writ of certiorari issue to review the decision of the Ninth Circuit.

Respectfully submitted,

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DATED: August 25, 1980.

By _____
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For Publication

IN THE UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

FILED

MAY 14 1980

ROSSYE DAWSON, individually and on behalf of all others similarly situated,	
Plaintiff-appellant,	No. 79-3246
vs.	OPINION
BEVERLEE A. MYERS,* et al.,	D.C. No. C 78-2350 MML
Defendants-Appellees.	

On Appeal from the United States District Court
for the Central District of California
The Honorable Malcolm M. Lucas, Presiding

Before: WRIGHT and ANDERSON, Circuit Judges, and SOLOMON,** District Judge.

J. BLAINE ANDERSON, Circuit Judge:

This is a class action challenging the State of California's transfer of assets rule which was relied upon to deny Medi-Cal benefits to members of the class. In short, this rule denies Medi-Cal benefits to any individual who has transferred assets so as to qualify under the financial eligibility requirements for Medi-Cal. The class members argue that the transfer rule conflicts with the federal Medicaid statutes and regulations, and they also challenge the rule's constitutionality based on due process and equal protection grounds. The court below rejected all of these arguments and upheld the transfer rule. We believe that the district court reached the correct result and affirm.

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*Beverlee A. Myers, the Director of the California State Department of Health Services, is the successor to Edwin W. Beach, the originally named defendant. Since Myers succeeded Beach prior to when this appeal was taken, we make the substitution under Fed. R. Civ. P. 25(d)(1) rather than Fed. R. App. P. 43(c)(1).

**The Honorable Gus J. Solomon, Senior United States District Judge for the District of Oregon, sitting by designation.

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I. BACKGROUND

A. Medicaid

Title XIX of the Social Security Act established the Medicaid program. 42 U.S.C. § 1396 et seq. This cooperative federal-state program is designed to provide medical assistance to certain classes of individuals who are in need of such assistance. Although states are not required to participate, if they choose to do so they must develop a plan which conforms to the federal guidelines. 42 U.S.C. § 1396(b). Despite the extensive federal standards (42 U.S.C. § 1396a), the individual states are given wide discretion in the administration of their local programs. Norman v. St. Clair, 610 F.2d 1228, 1230 (5th Cir. 1980). After a state's plan is approved by the Secretary of Health, Education and Welfare, the state then receives reimbursement for a portion of the funds which are expended. 42 U.S.C. § 1396.

A state which has chosen to adopt a Medicaid program has the option of deciding whether it should provide benefits to only one or to both of the statutorily-defined groups of needy persons. States participating in the program must provide assistance to the group which is referred to as the categorically needy.[1/] 42 U.S.C. § 1396a(10)(A). Generally, in order to be considered categorically needy, an individual must be receiving financial assistance, or be financially eligible for such assistance, under Title IV-A of the Social Security Act (Aid to Families with Dependent Children, referred to as AFDC) or Title XVI of the Social Security Act (Supplemental Security Income for the Aged, Blind, and Disabled, referred to as SSI).[2/]

When they establish their Medicaid program, the

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states have the option of also providing benefits to the group which is referred to as the medically needy. This group covers individuals who would qualify for AFDC or SSI except that they have sufficient income and resources to cover the essentials aside from their medical costs.[3/] The medically needy begin receiving assistance after they have incurred medical expenses which reduce their income (and assets) below a prescribed level. Thus, the chief distinction between the two groups is that the categorically needy have lower incomes and less resources than the medically needy.

B. Medi-Cal

California, through its Medi-Cal program, has voluntarily chosen to participate in the Medicaid program. In addition, California voluntarily chose to cover the medically needy as well as the categorically needy. California has adopted a comprehensive statutory and regulatory scheme to implement its Medi-Cal program.

As part of its plan, the California legislature adopted what is called a transfer of assets rule. Cal. (Welf. & Inst.) Code § 14015.[4/] Basically, this prevents persons from qualifying as medically needy if they have transferred assets for less than fair consideration within two years prior to their application for assistance. The transfer rule only applies to applicants in the medically needy group; it has no application at all to the categorically needy.

California has promulgated regulations which, among other things, establish eligibility requirements for the medically needy and implement the transfer rule.[5/] Under these regulations, an individual is eligible as medically needy only if his or her assets are valued at $1500 or less.

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22 Cal. Admin. Code § 50420. An individual's home, income-producing real property, and certain other assets are not counted toward the $1500 limitation. 22 Cal. Admin. Code §§ 50418, 50425-50489. Although this property is exempt insofar as determining eligibility, it remains potentially subject to California's recovery procedures. That is, after the individual dies, California is entitled to recover the cost of medical assistance it provided to the individual from the assets (including both exempt and nonexempt property) which are left in the individual's estate.

Under the regulations which implement the transfer rule, any transfer of assets (including exempt property) for less than adequate consideration creates a rebuttable presumption that the transfer was made for the purpose of establishing eligibility. Unless the applicant rebuts the presumption, the state can deny benefits on this basis.

C. Facts

Dawson, who originally filed this action, has died. Two other individuals, Beltran and Manahan, intervened. Beltran, who is 87, lives in an extended care facility. Manahan, who is 85, lives in a convalescent home. Both Beltran and Manahan were medically needy and otherwise qualified to receive Medi-Cal benefits. However, both were denied benefits based on the fact that they had transferred assets for less than adequate consideration prior to applying for Medi-Cal. Neither was able to overcome the presumption of ineligibility resulting from these transfers.

In their complaint, Beltran and Manahan (referred to as appellants), on behalf of themselves and others similarly situated, sought declaratory and injunctive relief invalidating and enjoining the California transfer rule. In

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addition, the appellants sought reimbursement for those amounts which they had been forced to pay because of the state's transfer rule. The district court certified a class consisting of all those who had been denied Medi-Cal benefits based on California's transfer rule.

On May 10, 1979, the district court granted California'a motion for summary judgment and denied the cross motion filed by the appellants. The court entered findings of fact and conclusions of law which held that the state's transfer rule did not conflict with the federal statutory and regulatory framework, nor did it amount to a denial of due process or equal protection. The appellants then brought this appeal.[6/]

II. DISCUSSION

The appellants make five distinct arguments against California's transfer rule. They claim that it creates an irrebuttable presumption in violation of the due process clause. Since the rule only applies to the medically needy, they contend that it also violates the equal protection clause. Furthermore, the appellants claim that the transfer rule conflicts with two different sections of the federal statutes (42 U.S.C. §§ 1346a(a)(10)(C), 1396a(a)(17)(B), as well as one section of the federal regulations (42 C.F.R. § 435.401). We address the challenges based on the federal statutes and regulations first because if the appellants' arguments are correct, we would not need to reach the constitutional issues. Dandridge v. Williams, 397 U.S. 471, 475-476, 25 L.Ed.2d 491, 90 S.Ct. 1153 (1970). Moreover, in addressing appellants' arguments, the cardinal principle of statutory construction must be kept in mind, that is, statutes should be construed to avoid constitutional questions. See Swain v. Pressley, 430 U.S. 372, 378 n.11,

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97 S.Ct. 1224, 51 L.Ed.2d 411 (1977)

A. 42 U.S.C. § 1396a(a)(10)(C)

Appellants' primary argument is that the California transfer rule conflicts with 42 U.S.C. § 1396a (a)(10)(C), which requires states providing benefits to the medically needy to cover "all individuals who would, except for income and resources" be eligible for SSI (and therefore come under the categorically needy classification), "and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services."[7/] The appellants attribute the following meaning to § 1396(a)(10)(C): "except for the definitional distinction that the medically needy may have higher income and resource levels, the states must use the same rules for the medically needy as for the categorically needy."

Under the Social Security Act, an SSI applicant whose assets exceed the eligibility levels may dispose of the excess assets in order to become eligible for SSI payments. 42 U.S.C. § 1382b(b). This has been administratively interpreted to permit the transfer of the excess assets for less than adequate consideration or as a gift. Social Security Claims Manual § 12507(a). According to the appellants, since transfer rules cannot be applied to SSI applicants (i.e., the categorically needy), they therefore cannot be applied to the medically needy.

The court below rejected the appellants' reasoning and concluded that the California transfer rule did not conflict with § 1396a(a)(10)(C). The court agreed with the appellants that California could not employ any substantive eligibility requirements on the medically needy which were more restrictive than those used for the categorically

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needy. Nevertheless, the court characterized the transfer rule as a collateral or procedural eligibility requirement which was permissible under the Social Security Act. While we agree with the district court that the California transfer rule does not conflict with § 1396a(a)(10)(C), we do not accept the semantic distinction which was relied upon.

We believe that the California transfer rule is properly characterized as a substantive eligibility requirement. It directly applies to the state's determination of whether an applicant's assets exceed the eligibility requirements.

In considering the appellant's argument, we must first turn to the language of the statute itself. Obviously, the face of this statute says nothing about prohibiting transfer rules such as California's.[8/]

The portion of the statute with which we are concerned may be divided into two parts. The first part provides that the medically needy group includes all who would, except for their income and resources, be eligibile for SSI. The second part provides that the medically needy group includes all who have insufficient income and resources, as determined under comparable standards, to pay for their medical care.

The first part specifically excepts income and resources when it equates SSI eligibility to the medically needy eligibility requirements. And so, while this provision does extend all of the SSI eligibility requirements to the medically needy, it does not do so for those which deal with the applicant's income and resources. Were this not the case, then there would be no distinction between the two groups. There can be no question but that the California

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transfer rule is an eligibility requirement which pertains to the applicant's income and resources. It therefore clearly comes within the exception to the first clause of the statute.

The second part may be read as requiring that the evaluation of the applicant's income and resources be determined by using comparable standards. Since an SSI applicant is apparently specifically allowed to transfer assets in the manner which is prohibited by the California transfer rule, we are faced with an inconsistent standard. Nevertheless, this does not make the California rule necessarily in conflict with this part of the statute. After all, the statute only requires the standards to be comparable, not identical. Comparable only means that there must be enough similar characteristics or qualities to make comparison appropriate. Webster's Third New International Dictionary, G.& C. Merriam Co. (1976). The other standards which are used for determining financial eligibility are similar enough to invite comparison. We therefore cannot say that the standards used by California to determine eligibility into the medically needy group (including the transfer rule) are not comparable to those which are used under the SSI program.

In support of their argument, the appellants claim that HEW, the agency charged with administering the Medicaid program, has interpreted § 1396a(a)(10)(C) in the same manner as they would have this court. Apparently, three different HEW Regional Medical Directors have written letters stating that state transfer rules are inconsistent with § 1396a(a) (10)(C) because they impose more restrictive eligibility requirements on the medically needy than on SSI applicants. See Fabula v. Buck, 598 F.2d 869, 873 (4th Cir.

1979). Although this court generally defers to an administrative agency's interpretation of the law which it is charged with administering, we are by no means bound by the agency's interpretation. Pacific Coast Medical Enterprises v. Harris, F.2d , slip op. 2516, 2525-2526 (9th Cir., March 28, 1980); Baker v. United States, 613 F.2d 224, 226-227 (9th Cir. 1980).

In the present case, we not only refuse to follow the letter interpretations, but we also refuse to attach any weight to them. Initially, we are convinced that our interpretation of § 1396a(a)(10)(C) is correct, that is, the California transfer rule does not conflict with the statute. This court's "deference does not extend to agencies' construction which conflict with statutory directives." Pacific Coast, supra, slip op. at 2526. While regional administrators may be writing letters disapproving of state transfer rules, HEW as a whole has approved California's Medi-Cal program (and the transfer rule). By this approval, and by not taking any action against California because of the transfer rule, HEW "has in effect expressed its view that the plan is in compliance with applicable statutory and regulatory requirements." Michael Reese Physicians & Surgeons, S.C. v. Quern, 606 F.2d 732, 735-736 (7th Cir. 1979). Based on the preceding, not only do we believe that the letter rulings should not be followed, but we also believe that HEW's general acceptance of California's Medi-Cal program supports our interpretation.

As further support for their argument under § 1396a(a)(10)(C), the appellants rely upon the subsequent legislative history of the Medicaid program. In 1978, as part of the Medicare-Medicaid Administrative and Reimbursement Reform Act, the Senate Finance Committee proposed an

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amendment to the Medicaid statute which would have specifically required states to adopt transfer rules such as California's. S. Rep. No. 95-1111, 95th Cong., 2d Sess., 24-25 (1978). Apparently, relying upon what we have already concluded was an erroneous agency interpretation of § 1396a(a)(10)(C), the Senate Committee said that the states were not able to adopt transfer rules under present law. Id. We recognize that the pronouncements of legislative committees as to the meaning of previously enacted statutes are often afforded considerable deference. Sioux Tribe of Indians v. United States, 316 U.S. 317, 329-330, 62 S.Ct. 1095, 86 L.Ed. 1501 (1942). Nevertheless, courts are not bound by such pronouncements and it has been suggested that subsequently expressed Congressional views should not be relied upon at all. Mathews v. Weber, 423 U.S. 261, 272 n.7, 96 S.Ct. 549, 46 L.Ed.2d 483 (1976). Since the Senate Committee was apparently relying upon the erroneous administrative interpretation, and because we remain convinced that our interpretation of § 1396a(a)(10)(C) is correct, we choose not to accord any deference to the latter legislative pronouncements.

We conclude that California's transfer rule does not conflict with 42 U.S.C. § 1396a(a)(10)(C).

B. 42 U.S.C. § 1396a(a)(17)(B)

The appellants argue that the California transfer rule violates 42 U.S.C. § 1396a(a)(17)(B).[9/] This section requires states to only consider the income and resources which are "available" to the applicant in determining eligibility. The California transfer rule assumes the availability of assets, which, according to the appellants, are no longer available to the applicant.

The appellants' argument may be correct under what

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we believe is an overly rigid and literal interpretation of the term "available" under § 1396a(a)(17)(B). We refuse to interpret this statute as equating available with present record title. This would be inconsistent with the approach which is taken under the Medicaid program.

Initially, "we do not lose sight of the [Medicaid] statute's strong emphasis upon flexibility in determining eligibility." Norman, supra, 610 F.2d at 1240. In another context the Supreme Court interpreted § 1396a(a)(17) as conferring broad discretion on the states to adopt reasonable standards. Beal v. Doe, 432 U.S. 438, 444, 97 S.Ct. 2366, 53 L.Ed.2d 464 (1977).[10/] The California transfer rule presumes that an asset remains available to an applicant after the applicant has given it away, or sold it for less than adequate consideration. We find nothing in the plain language of this statute which would prohibit such a rule, nor is there anything in the legislative history which equates "available" as requiring present record title or ownership.

To the extent that the regulations address the definition of "available," they support our interpretation. Under the regulations, a state is allowed to examine an applicant's income and assets for a six-month prospective period in determining eligibility. 42 C.F.R. §§ 435.831(a), 435.845(b). Since a state is authorized to consider future assets, it must follow that it should also be allowed to consider those assets which have been recently disposed of under circumstances which indicate that the purpose was to qualify for public medical assistance.

We hold that California's transfer rule does not conflict with 42 U.S.C. § 1396a(17)(B).

C. 42 C.F.R. § 435.401

Appellants also claim that the California transfer

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rule is inconsistent with 42 C.F.R. § 435.401.[11/] This regulation provides that a state Medicaid agency cannot use requirements for determining eligibility for the medically needy which are "more restrictive" than those used for the categorically needy. Since the California transfer rule is a more restrictive requirement, the appellants reason that it therefore violates § 435.401.

While we agree that the California transfer rule imposes a more restrictive requirement on the medically needy, we do not believe that § 435.401 has any bearing on the validity of financial eligibility requirements such as the transfer rule.

First of all, if we were to give § 435.401 the broad reading attributed to it by the appellants, we would be reading an inconsistency into the federal statutory and regulatory framework. The Medicaid program is designed to provide benefits to two differently situated groups. The medically needy are those individuals who have more available income and resources than the categorically needy. By definition, different financial requirements apply to the medically needy than to the categorically needy. Only when § 435.401 is read as not applying to financial requirements, such as the transfer rule, can it be viewed consistently with the other Medicaid statutes and regulations.

After all, § 435.401 is merely one of five sections under the general heading entitled: "Subpart E - General Eligibility Requirements." There is absolutely no discussion of financial eligibility requirements in any of the other sections of this subpart. Instead, the focus of all of the sections is directed toward much more general concerns, such as eligibility requirements which are based on citizenship, alienage, or state residence. In addition, a thorough reading of the statutes and regulations shows

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that the sections of Subpart E parallel the subsections of 42 U.S.C. § 1396a(b). From this it is apparent that Subpart E (including § 435.401) was designed to carry out the statutory mandate of 42 U.S.C. § 1396a(b) which does not involve financial eligibility requirements. See, e.g., Pacific Coast, supra, slip op. at 2526.[12/] And finally, there are three specific subparts which cover the financial eligibility requirements. Subpart G states the general financial eligibility requirements, Subpart H states the financial eligibility requirements for the categorically needy, and Subpart I states the financial eligibility requirements for the medically needy. These specific and detailed guidelines for financial eligibility requirements must control over the general rule of § 435.401.

We conclude that 42 C.F.R. § 435.401 does not apply to financial eligibility requirements and therefore there is no conflict between it and the California transfer rule.

D. Due Process

In their opening brief, the appellants claim that the transfer rule creates an irrebuttable presumption in violation of the due process clause. In their reply brief, the appellants call it an "effectively" irrebuttable presumption. We disagree with either characterization and find that the transfer rule creates a rebuttable presumption which is permissible under the due process clause.

The California transfer rule obviously does not create an irrebuttable presumption. After all, the regulations expressly provide that the presumption may be overcome by evidence that the applicant had adequate resources for support and medical care at the time of the transfer of property. 22 Cal. Admin. Code § 50409(b)(2). Such a determination can be based on "such things as the applicant's . . . age, health, life expectancy, and ability to understand

[the] extent of [his or her] resources." Id. This would mean that if a person was in good health at the time of the transfer, then the presumption might be rebutted because the person would have no reason to anticipate any large expenditure for medical care and support.

The appellants argue that it is an "effectively" irrebuttable presumption because the applicant is precluded from relying on his or her subjective intent. According to the appellants, this excludes the two most likely explanations for this type of transfer, which are: (1) the applicant was unaware of Medi-Cal benefits, and/or (2) a desire to avoid probate. While the state could have considered these subjective considerations, we cannot say that the failure to do so creates a due process violation. California's objective test for determining how the presumption can be overcome does not create an effectively irrebuttable presumption which might run afoul of the due process clause.

E. Equal Protection

The appellants' final argument is based on equal protection grounds. They claim that there is no rational basis for treating the medically needy any differently from the categorically needy. According to the appellants, the medically needy are in the identical situation as the categorically needy, that is, in need of medical care and without sufficient income or resources to pay for it. Since the "transfer of assets" rule only applies to the medically needy, the appellants argue that it violates the equal protection clause because there is no reasonable basis for the disparate treatment between the two groups.

We fail to see how the application of the transfer of assets rule to the medically needy group gives rise to

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even a colorable constitutional claim under the equal protection clause.

Initially, we note that the two groups are not identically situated. By definition, the categorically needy have less income and resources than the medically needy. Furthermore, Congress has obviously viewed the two groups differently, or, at least, as not being identically situated. Why else would Congress have left the decision to provide benefits to the medically needy entirely up to the individual state? It must be remembered that the categorically needy receive benefits regardless of whether a state adopts a medicaid program under Title XIX. However, the medically needy only become entitled to benefits if a state first adopts a program, and, secondly, if the state elects to include the medically needy group in its benefit program.

In addition, California has a rational basis for its transfer rule. California is confronted with two competing interests, the protection of a limited public treasury, and the provision of benefits to those who are in need. The transfer rule was a reasonable response to these conflicting concerns. Under the rule, benefits are provided to those individuals who, in fact, have a financial need, and benefits are denied to the individuals who have artificially created a need by disposing of assets for less than fair consideration.

We hold that California's transfer rule is rationally related to the legitimate government objectives of protecting the public treasury and discouraging intentional impoverishment so as to qualify under a public assistance program. Any disparate treatment resulting from the application of the rule is sufficiently rational to be upheld

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against appellants' equal protection challenge. See Dandridge, supra, 397 U.S. at 471; Richardson v. Belcher, 404 U.S. 78, 83-84, 92 S.Ct. 254, 30 L.Ed.2d 231 (1972); Sims v. Harris, 607 F.2d 1253 (9th Cir. 1979).

III. CONCLUSION

In upholding the California transfer rule, we recognize that the majority of the courts which have been faced with similar challenges have reached the opposite conclusion. See, e.g., Caldwell v. Blum, F.2d , No. 79-7864 (2d Cir. April 10, 1980); Fabula v. Buck, 598 F.2d 869 (4th Cir. 1979); Udina v. Walsh, 440 F.Supp. 1151 (E.D. Mo. 1977); Buckner v. Maher, 424 F.Supp. 366 (D. Conn. 1976), aff'd 434 U.S. 898, 98 S.Ct. 290, 54 L.Ed.2d 184; Owens v. Roberts, 377 F.Supp. 45 (M.D. Fla. 1974); contra, Rinefierd v. Blum, 412 N.Y.S. 2d 526 (App. Div. 1979); Lerner v. Division of Family Services, 235 N.W. 2d 478 (Wis. 1975). Nevertheless, for the reasons stated in this opinion, we are convinced that our analysis of the question is correct.

AFFIRMED.[13/]

FOOTNOTES

1/ The regulations define this group as follows:

> "Categorically needy" means aged, blind or disabled individuals or families and children who are otherwise eligible for medicaid and who meet the financial eligibility requirements for AFDC, SSI, or an optional State supplement;"

42 C.F.R. § 435.4.

2/ States have the option of using more restrictive criteria than those used under the AFDC or SSI programs. California has not chosen this option and so this opinion does not deal with those provisions of the Medicaid Act which would then come into play.

3/ The regulations define this group as follows:

> "Medically needy" means aged, blind, or disabled individuals or families and children who are otherwise eligible for medicaid and whose income and resources are above the limits set under the medicaid State plan;"

42 C.F.R. § 435.4.

4/ The statutory part of the transfer rule provides as follows:

> "The providing of health care under this chapter shall not impose any limitation or restriction upon the person's right to sell, exchange or change the form of property holdings nor shall the care provided constitute any encumbrance on the holdings. However, any transfer of the holdings by gift or, knowingly, without adequate and reasonable consideration, shall be presumed to constitute a gift of property with intent to qualify for assistance and such act shall disqualify the owner for further aid for a period determined under standards established by the director, and in no event for less than half of the period that the capital value of the transferred property would have supplied the person's maintenance needs based on his circumstances at the time of his transfer plus the cost of any needed medical care."

Cal. (Welf. & Inst.) Code § 14015.

5/ The transfer rule is implemented, for the most part, through 22 Cal. Admin. Code §§ 50408, 50409. The first section (§ 50408) states the general conditions for when the transfer of property will not result in ineligibility. The rule and the procedure for overcoming the presumption are then stated in § 50409:

"(a) Transfer of property shall result in ineligibility for Medi-Cal if the transfer did not meet at least one of the conditions specified in Section 50408 or the transfer was in return for an enforceable life care contract which includes complete medical care.

"(b) Transfer of property without adequate consideration shall result in ineligibility for Medi-Cal if the transfer was made to establish eligibility or to reduce the share of cost.

"(1) It shall be presumed that property transferred without adequate consideration was for the purpose of establishing eligibility or to reduce the share of cost as limited by (2).

"(2) To overcome the presumption, the applicant or beneficiary has the burden of establishing by objective facts, rather than statement of subjective intent, that this presumption is not correct. The applicant or beneficiary shall provide evidence that adequate resources were available at the time of the transfer of property for support and medical care considering such things as the applicant's or beneficiary's age, health, life expectancy, and ability to understand extent of resources.

"(A) The declaration of another purpose, such as to avoid probate, by itself, shall not be sufficient to overcome the presumption. A showing that the sole purpose of the transfer was for reasons other than to establish eligibility or to reduce the share of cost shall be supported by evidence such as that specified above.

"(B) The establishment of the fact that the applicant or beneficiary did not have specific knowledge of the availability or benefits of the Medi-Cal program is not sufficient to overcome the presumption."

6/ The district court concluded that it had jurisdiction under 28 U.S.C. § 1343(3) & (4) (civil rights jurisdiction) and under 28 U.S.C. § 1331 (federal question jurisdiction). It is unclear whether jurisdiction was properly invoked under 28 U.S.C. § 1343. See Chapman v. Houston Welfare Rights Org., 441 U.S. 600, 99 S.Ct. 1905, 60 L.Ed.2d 508 (1979); Doe v. Klein, 599 F.2d 338 (9th Cir. 1979). Nevertheless, the amount in controversy exceeds $10,000 and so the district court did clearly have federal question jurisdiction (28 U.S.C. § 1331). Brown v. Stanton, F.2d No. 79-1459, slip op. 2 n.1 (7th Cir. 1980); see Chapman, supra, 60 L.Ed.2d at 515. Since the appellants filed a timely notice of appeal from the final judgment, this court has jurisdiction to consider the appeal under 28 U.S.C. § 1291.

7/ This statute provides, in part, as follows:

"A state plan for medical assistance must ---provide---

"(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary--

"(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

"(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

* * *"

(emphasis added to show that portion of the statute which the appellants rely upon)

42 U.S.C. § 1396a(a)(10).

8/ At one point, appellants suggest that states can only use requirements which are explicitly authorized by the federal statute. We were unable to find any provision of the statute which said this. In the absence of some expression by Congress to the contrary, we decline to read such a prohibition into a statute which is, after all, establishing a cooperative federal state program. See, New York Department of Social Services v. Dublino, 413 U.S. 405, 93 S.Ct. 2507, 37 L.Ed.2d 688 (1973) ("It will not be presumed that a federal statute was intended to supersede the exercise of the power of the state unless there is a clear manifestation of an intention to do so." 413 U.S. at 413, quoting Schwartz v. Texas, 344 U.S. 199, 202-203, 73 S.Ct. 232, 97 L.Ed. 231 (1952)).

9/ This statute provides in part as follows:

"A state plan for medical assistance must---

"include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits . . .

* * *"

(emphasis added to show that portion of the statute which the appellants rely upon)

42 U.S.C. § 1396a(a)(17).

10/ The Supreme Court was considering the extent of medical assistance which the states were required to provide. Beal, supra, 432 U.S. at 444.

11/ This regulation provides as follows:

"(a) A medicaid agency may not impose any eligibility requirement that is prohibited under title XIX of the Act.

"(b) The agency must base any optional group covered under subparts B and C of this part on reasonable classifications that do not result in arbitrary or inequitable treatment of individuals and groups and that are consistent with the objectives of title XIX.

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"(c) The agency must not use requirements for determining eligibility for optional coverage groups that are--

"(1) For families and children, more restrictive than those used under the State's AFDC plan; and

"(2) For aged, blind, and disabled individuals, more restrictive than those used under SSI, except for individuals receiving an optional State supplement as specified in § 435.230 or individuals in categories specified by the agency under § 435.121."

(emphasis added to show that portion of the regulation which the appellants rely upon)

42 C.F.R. § 435.401.

12/ In Pacific Coast, supra, this court noted that "[e]xisting regulations must be construed in light of the statutory mandates under which they issue." Slip op. at 2526.

13/ Appellants also ask this court, providing they prevail on this appeal, to grant the full measure of relief requested in their complaint and provide notice to all class members. Because we affirm the district court, it is unnecessary for us to address the propriety of this request.

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CLERK, U. S. DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

ENTERED
MAY 10 1979
CLERK, U. S. DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
BY DEPUTY

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

ROSSYE DAWSON, individually and on behalf of all others similarly situated, Plaintiff, v. EDWARD BEACH, et al., Defendants.	NO. 78-2350 MML(Sx) PROPOSED SUMMARY JUDGMENT
ANTONIA BELTRAN AND ENOSINSIO MANAHAN, Individually and on behalf of all other similarly situated, Intervenor-Plaintiff,	

This cause came on to be heard on motion of the defendants for summary judgment and on cross-motion of the plaintiffs and intervenor plaintiffs for summary judgment, pursuant to Rule 56 of the Federal Rules of Civil Procedure, and the court having considered all papers, and the court having heard the argument of counsel, and due deliberation having been

had thereon, it is

ORDERED, that plaintiffs' cross-motion for summary judgment be and the same hereby is denied, and it is further

ORDERED, that defendants' motion for summary judgment be and the same hereby is granted, and it is further

ORDERED, ADJUDGED AND DECREED that the action be dismissed on its merits, and that EACH SIDE BEAR OWN defendants recover their costs of suit.

DATED: 5/10/79.

MALCOLM M. LUCAS
United States District Judge

FILED

MAY 10 1979

CLERK, U. S. DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
BY [illegible] DEPUTY

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

ROSSYE DAWSON, individually and on behalf of all others similarly situated, Plaintiff, v. EDWARD BEACH, et al., Defendants.	NO. CV-78-2350-MML FINDINGS OF FACT AND CONCLUSIONS OF LAW
ANTONIA BELTRAN and ENOSINSIO MANAHAN, individually and on behalf of all others similarly situated, Intervenor-Plaintiff,	

This cause came on for hearing on defendants' Motion for Summary Judgment and plaintiffs' Cross-Motion for Summary Judgment, and the Court, having considered the memoranda of points and authorities filed by the parties in support of such motions and the documents and exhibits thereto, and the stipulation of the parties, and having heard oral argument by the parties in support of such motions, finds the facts and states the conclusion of law as follows:

FINDINGS OF FACT

1. With respect to Rossye Dawson.

a. On February 18, 1977, an application for Medi-Cal was filed on behalf of Rossye Dawson;

b. The County of Riverside Department of Public Social Services approved the application pending a property verification;

c. On May 17, 1977, the County of Riverside Department of Public Social Services sent a Notice of Action letter to Rossye Dawson determining that she was no longer eligible for Medical-Cal because she had transferred property without adequate consideration in violation of Title 22, California Administrative Code section 50409;

d. Rossye Dawson filed a request for a fair hearing, which was held on September 14, 1977;

e. The hearing officer found that the transfer of property for inadequate consideration was made in May 1977, that Rossye Dawson had failed to overcome the presumption that the transfer was made for the purpose of qualifying for Medi-Cal, and that therefore her claim for Medi-Cal benefits should be denied;

f. The proposed decision of the hearing officer was adopted by the Director of the State Department of Health on February 15, 1978;

g. Rossye Dawson has never sought judicial review of the director's decision by filing a petition for writ of mandate pursuant to section 1094.5 of the California Code of Civil Procedure; and

h. On or about October 30, 1978, counsel for Rossye

Dawson filed a "Certificate of Counsel re Death of Plaintiff." No substitution for the deceased plaintiff has been made.

2. With respect to intervenor Enosinsio Manahan:

a. On April 12, 1978, an application for Medi-Cal was filed on behalf of Mr. Manahan;

b. The Orange County Department of Social Services denied his application on the ground that he had transferred property in order to be eligible for Medi-Cal in violation of, inter alia, Title 22 California Administrative Code section 50409;

c. A fair hearing was requested and held on July 6 and 7, 1978 on the county's denial of Medi-Cal;

d. The hearing officer found that Mr. Manahan had overcome the presumption that the transfer of property was for the purpose of qualifying for Medi-Cal. The hearing officer recommended that he be eligible for Medi-Cal once he met the Medi-Cal property limit spend-down.

e. On January 12, 1978, the Director of the State Department of Health Services reversed the proposed decision of the hearing officer. The director found that Mr. Manahan had not overcome the presumption; and

f. He has not sought judicial review of the director's decision by filing a petition for writ of mandate in the state court pursuant to California Code of Civil Procedure section 1094.5.

3. With respect to intervenor Antonia Beltran:

a. On October 27, 1978, she re-applied for Medi-cal benefits;

b. The Notice of Action dated January 8, 1979 indicated that the denial of Medi-Cal eligibility was based on a transfer of property in 1977.

c. She did not request a fair hearing from the determination of the county, and no fair hearing was held.

4. Except for the application of the transfer of assets rule to these three individuals, they would be eligible for Medi-Cal coverage under the state's medically needy program.

5. Defendant Beverlee A. Myers, successor to Edwin W. Beach, is the Director of the California State Department of Health Services, successor to the State Department of Health.

6. Defendant Elisabeth Lyman, successor to Bruce Yarwood, is the Acting Chief Deputy Director of the Medical Care Services and Medical Care Standards Division of the State Department of Health Services.

7. To the extent that any of the following conclusions of law are deemed findings of fact, the same are incorporated herein by reference.

CONCLUSIONS OF LAW

1. The Court has jurisdiction over this case pursuant to 28 U.S.C. §1343(3), (4), as this is an action authorized by 42 U.S.C. §1383 to redress the deprivation of rights under color of state law. The Court has pendent jurisdiction over any claims not specifically authorized pursuant to 42 U.S.C. §1983. Jurisdiction is also conferred by 28 U.S.C. §1331, as there is more than $10,000.00 in controversy. This case has been certified as a class action.

2. Rossye Dawson lacks capacity to sue as she is deceased and no substitution has been made for her pursuant to Federal Rules of Civil Procedure section 25(a)(1).

3. The federal Medicaid Program, Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., is a system of cooperative federalism in which the states and other jurisdictions have the option to participate, and to receive partial reimbursement for services provided. If they decide to participate, the states are required to operate their Medicaid Program within the contours of the federal statute and regulations, and to submit a state plan to the Secretary of the Department of Health, Education, and Welfare that comports with controlling federal laws. In order to be eligible for reimbursement, the states which decide to participate must comply with the mandatory requirements established by the Social Security Act as interpreted and implemented by HEW. Townsend v. Swank, 404 U.S. 282, 286 (1971); King v. Smith, 392 U.S. 309, 333 (1968); County of Alameda v. Carleson, 5 Cal.3d 730, 739 (1971); Wong v. Brian, CCH Medicare & Medicaid Guide, [1974] Transfer Binder, ¶26, 605 (Cal.Ct. App. 1972).

4. Once a state decides to participate, it must provide Medicaid benefits to the "categorically needy", who are individuals meeting both the categorical requirements of being aged, blind, or disabled, and also the financial eligibility requirements. 42 U.S.C. §1396a(a)(10)(A); 42 C.F.R. §435.120; see Friedman v. Berger, 547 F.2d 724, 726 (2d Cir. 1976), cert. denied 430 U.S. 984 (1977); Wong v. Brian, supra, ¶26, 605 at 9013.

5. In addition, states have the option of providing Medicaid assistance to the so-called "medically needy" who are individuals meeting the categorical requirements of being aged, blind or disabled, but who have incomes or resources above the financial requirements. 42 U.S.C. §1396a(a)(10)(C); 42 C.F.R. §435.300 et seq.; see Friedman v. Berger, supra; Wong v. Brian, supra.

6. California has opted to participate in the Medicaid Program, and has further opted to provide assistance to the medically needy. 22 Cal.Adm. Code §60249(a)(1); Wong v. Brian, supra.

7. The general rule is that recipients of Supplemental Security Income ("SSI"), who are aged, blind, or disabled individuals receiving federal cash benefits, are categorically needy and are therefore automatically eligible for Medicaid. 42 U.S.C. §1396a(a)(10(A). California, as well as other states, has been given the option by Congress of using a different eligibility test for the categorically needy than that they be recipients of SSI. Under this test, a state can use more restrictive financial eligibility conditions than those set out in the SSI program, but no more restrictive than those in effect in the state on January 1, 1972. 42 U.S.C. §1396a(f); 42 C.F.R. §431.121; see Hayes v. Stanton, 512 F.2d 133, 137-138 (7th Cir. 1975); West v. Cole, 390 F.Supp. 91, 95-96 (N.D. Miss. 1975); Gray Panthers v. Secretary, Department of Health, Education and Welfare, 461 F.Supp. 319, 321 (D.D.C. 1978).

. . . . . .

8. In its Medicaid Program, known in this state as Medi-Cal, California has not selected this option, and therefore must provide, and does provide, automatic categorical assistance to all recipients of SSI. Cal.Adm. Code §50227.

9. The federal Medicaid statute requires those states which provide medically needy benefits to include as eligible "all individuals who would, except for income and resources, be eligible to have paid with respect to them Supplemental Security Income benefits. . . . " 42 U.S.C. §1396a(a)(10)(C)(i).

10. A state may not impose conditions of eligibility on the medically needy that are more restrictive than those imposed on the categorically needy, that is, recipients of SSI. 42 C.F.R. §435.401(c). Of course, a state may impose collateral restrictions on the medically needy that are not imposed on the categorically needy. 42 U.S.C. §1396a(a)(17)(A); 45 CFR §233.10(a)(1)(ii)(B).

11. Cal.Welf. & Inst. Code §14015 and 22 Cal.Adm. Code §50409 are designed to eliminate fraudulent practices affecting eligibility for benefits. The federal statute is concerned with substantive eligibility requirements only, and does not place any specific restrictions on the state's right to police fraud. Consequently, the transfer of assets rule is a procedural regulation which is not prohibited by 42 USC §1396a(a)(10)(C)(i).

12. Cal.Welf. & Inst. Code §14015 and 22 Cal.Adm. Code §50409 do not violate 42 U.S.C. §1396a(a)(17)(B) or 42 CFR §435.845. The purpose of these state law provisions is to deter transfers of assets solely for the purpose of qualification.

To the extent an asset is transferred for the purpose of qualifying for benefits, the asset should be treated as being available for the applicant's use.

13. Cal.Welf. & Inst. Code §14015 and 22 Cal.Adm. Code §50409 are not in conflict with any federal law or regulation governing the Medicaid/Medi-Cal program. They do not violate the Supremacy Clause of the United States Constitution

14. Cal. Welf. & Inst. Code §14015 and 22 Cal.Adm. Code §50409 do not establish an irrebutable presumption that a transfer of assets was made with the intent of gaining eligibility and so do not violate the due process clause of the Fourteenth Amendment to the United States Constitution.

15. A rational distinction between SSI recipients and the medically needy is made in Cal. Welf. & Inst. Code §14015 and 22 Cal. Adm. Code §50409. The state has an interest in assuring that medical assistance benefits are dispersed only to those who are truly in need. Those receiving SSI by definition are in financial need. It is rational for the state to scrutinize transfers of assets by the medically needy to assure that financial eligibility is not improperly manufactured. The Court therefore holds that the equal protection clause of the Fourteenth Amendment has not been violated by Cal.Welf. & Inst. Code §14015 and 22 Cal.Adm. Code §50409.

16. To the extent that any of the foregoing findings of fact are deemed conclusions of law, the same are incorporated herein by reference.

17. The plaintiff's motion for summary judgment is

denied, and the defendants' motion for summary judgment is granted. Judgment shall be entered accordingly.

Dated: May 10, 1979

Malcolm M. Lucas
United States District Judge

FILED

IN THE UNITED STATES COURT OF APPEALS JUL 30 1980

FOR THE NINTH CIRCUIT

RICHARD H. DEAN
CLERK, U.S. COURT OF APPEALS

ROSSYE DAWSON, individually and on behalf of all others similarly situated,

Plaintiff-Appellant,

vs.

BEVERLEE A. MYERS, et al.,

Defendants-Appellees.

No. 79-3246

O R D E R

Before: WRIGHT and ANDERSON, Circuit Judges, and SOLOMON,* District Judge.

The panel as constituted in the above case has voted to deny the petition for rehearing and to reject the suggestion for a rehearing en banc.

The full court has been advised of the suggestion for en banc rehearing, and no judge of the court has requested a vote on the suggestion for rehearing en banc. Fed. R. App. P. 35(b).

The motion of the Secretary of Health and Human Services for permission to file an amicus curiae brief is DENIED.

The petition for rehearing is denied and the suggestion for a rehearing en banc is rejected.

*The Honorable Gus J. Solomon, Senior United States District Judge, District of Oregon, sitting by designation.

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1. United States Constitution, 14th Amendment, §1 (due process and equal protection clauses):

> "... nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

2. Title 42, United States Code, §§1396a(a)(10)(C), 1396a(a)(17)(B):

> "A State plan for medical assistance must
>
> (10) provide -
>
> (C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary -
>
> (i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and
>
> (ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope ...."

[and]

> "(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which ... (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or

recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits ...."

3. California Welfare & Institutions Code, §14015:

"The providing of health care under this chapter shall not impose any limitation or restriction upon the person's right to sell, exchange or change the form of property holdings nor shall the care provided constitute any encumbrance on the holdings. However, any transfer of the holdings by gift or, knowingly, without adequate and reasonable consideration, shall be presumed to constitute a gift of property with intent to qualify for assistance and such act shall disqualify the owner for further aid for a period determined under standards established by the director, and in no event for less than half of the period that the capital value of the transferred property would have supplied the person's maintenance needs based on his circumstances at the time of his transfer plus the cost of any needed medical care."

4. Title 42, Code of Federal Regulations, 435.401 (c)(2):

"(c) The agency must not use requirements for determining eligibility for optional coverage groups that are -

...(2) For aged, blind and disabled individuals, more restrictive than those used under SSI, except for individuals receiving an optional State supplement as specified in §435.230 or individuals in categories specified by the agency under §435.121."

5. Title 22, California Administrative Code, §§50409, 50411:

"50409. Transfer of Property Which Results in Ineligibility. (a) Transfer of property shall result in ineligibility for Medi-Cal if the transfer did not meet at least one of the conditions specified in Section 50408 or the transfer was in return for an enforceable life care contract which includes complete medical care.

(b) Transfer of property without adequate consideration shall result in ineligibility for Medi-Cal if the transfer was made to establish eligibility or to reduce the share of cost.

(1) It shall be presumed that property transferred without adequate consideration was for the purpose of establishing eligibility or to reduce the share of cost.

(2) To overcome the presumption, the applicant or beneficiary has the burden of establishing by objective facts, rather than statement of subjective intent, that this presumption is not correct. The applicant or beneficiary shall provide evidence that adequate resources were available at the time of transfer of property for support and medical care considering such things as the applicant's or beneficiary's age, health, life expectancy, and ability to understand extent of resources.

(A) The declaration of another purpose, such as to avoid probate, by itself, shall not be sufficient to overcome the presumption. A showing that the sole purpose of the transfer was for reasons other than to establish eligibility or to reduce the share of cost shall be supported by evidence such as that specified above.

(B) The establishment of the fact that the applicant or beneficiary did not have specific knowledge of the availability or benefits of the Medi-Cal program is not sufficient to overcome the presumption."

"50411. Period of Ineligibility Due to Transfer of Property. (a) Following a determination of ineligibility due to the transfer of property, there shall be a period of ineligibility. This period shall be the time during which the net market value of the property at the time of transfer, less consideration received, would have supported the applicant or beneficiary and the applicant's or beneficiary's family.

(b) The period of ineligibility shall be computed in the following manner:

(1) Determine the net market value of the property at the time of transfer less any consideration received which is the net value of the property transferred.

(2) Determine the portion of the net value of the property transferred which, if included in the property reserve at the time of transfer, would not have caused such reserve to exceed the property limit that was applicable at that time.

(3) The portion of the net value of the property transferred that would not have fallen within the property limit at the time of transfer is the excess net value of the property transferred and shall be used to determine the period of ineligibility.

(4) The number of months in the period of ineligibility shall be determined by dividing the excess net value of the property transferred by the monthly maintenance need for the applicant or beneficiary and the applicant's or beneficiary's family. The maintenance needs used shall be the maintenance needs in effect during each individual month since the date of the transfer. Income received by the family after the transfer shall not affect this computation.

(5) The period of ineligibility may be further reduced by deducting the actual cost to the applicant or beneficiary of the following:

(A) Medical expenses.
(B) Out-of-home care costs in excess of the maintenance needs.
(C) Major home repairs necessary to put the home into a liveable condition.

(c) The period of ineligibility shall begin the first of the month following the date the transfer which resulted in ineligibility occurred, unless a 10-day notice is required and cannot be given. In that case, the period of ineligibility shall begin the first of the next month.

(d) The period of ineligibility shall end when any of the following situations occur:

(1) The property which was transferred and caused ineligibility is reconveyed to the applicant or beneficiary.
(2) The applicant or beneficiary receives adequate consideration for the property.
(3) Deduction of the amounts specified in (b)(4) and (5) has reduced the excess net market value to zero."

6. Social Security Administration Claims Manual, §12507(a):

"12507. Disposition or transfer of Resources Prior to Filing Application

(a) General

The valid disposal or transfer, as by sale or gift, of a resource prior to the filing of an SSI program application, does not preclude eligibility for payment, even though retention of the resource would have placed an individual's or couple's resources over the applicable limit. This is true with respect to cash and real or personal property and also true though the resource may have been given as a gift or sold for less than its market value to a relative or friend.

In addition, an individual may also reduce his resources, for the purpose of being within the applicable limits, by prepaying debts (such as rent, taxes, installment charges, etc.). (Note: where a renter has prepaid rent, do not count the rental value of the dwelling as unearned income.)

However, such prepayments must be bona fide and irrevocable. If an individual has the legal right to get a prepayment back, those funds available to him are still his resource."